EI Partnerships
Standards of Care

Massachusetts Department of Public Health
Bureau of Family and Community Health
Division of Perinatal and Early Childhood Health
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A Introduction

A.1 Description of this document

This guide describes the standards of care for the Early Intervention (EI) Partnerships program. Beginning with an overview of the goals and objectives, the document then presents each goal with its corresponding standards of care.

This document will be reviewed with EI Partnerships vendors and other perinatal and early childhood experts during fiscal year 2004, and changes will be made as necessary.

This guide should be used in conjunction with three other program documents:

- EI Partnerships RFR
- Your vendor-specific contract
- EI Partnerships Data and Billing Guide (to be distributed by June 15th, 2003)

A.2 Overview of Program

The purpose of EI Partnerships is to provide the early identification of maternal and infant risk, and linkage to services to prevent or mitigate poor health and/or developmental outcomes.

Early Intervention programs develop an enhanced Maternal Child Health (MCH) team to provide services to pregnant women, mothers, infants and their families. This MCH team includes a minimum of three core members: a maternal and child health nurse, a mental health clinical professional, and a family liaison. In addition, appropriate connections with nutrition and lactation consultant services are assured.

The MCH Team provides the following core services: a Comprehensive Health Assessment (CHA) of pregnant women, mothers, infants and their families; brief intervention[1] including health education and risk reduction counseling; and, connections with appropriate health care and human services and resources, as indicated by the assessment and family choice.

EI Partnerships provides a flexible approach to home based service delivery with the development and implementation of the Family Care Plan (FCP) as the key to each family's involvement in the program.

Desired outcomes for the program are:

- ❖ Improved maternal health and perinatal outcomes.
- ❖ Optimal infant growth and development through the first year of life.

[1] Brief Intervention is defined here as recognizing a problem, or potential problem, as soon as possible and mitigating the harm that the problem will cause. It includes creating opportunities to raise awareness, share knowledge, and support a person in thinking about making changes to improve their health.

To achieve these outcomes, EI Partnerships has the following goals:

Goal 1: Improve access to and utilization of health care services.

Goal 2: Improve nutrition, physical activity, and breastfeeding initiation and duration rates.

Goal 3: Ensure a safe and healthy social, emotional, and physical environment.

Goal 4: Strengthen local perinatal and early childhood systems through collaboration with community entities and active engagement of families.

These four goals are evaluated by the following Performance Measures:

1. 100% of families served by the program have at least one visit, at which time a **Comprehensive Health Assessment (CHA)** is completed and a **Family Care Plan (FCP)** for follow-up and referral is jointly developed by the nurse and the family.

2. 100% of families receive health education and counseling appropriate to the families' needs and based on the CHA.

3. 90% of pregnant women have adequate prenatal care measured by the Adequacy of Prenatal Care Utilization (APNCU) Index, developed by Kotelchuck.

4. 90% of the children have completed age-appropriate immunizations by 12 months of age.[2]

5. 90% of mothers have had a four-six week postpartum visit with a health care provider.[3]

6. 95% of infants have:
   - Documented neonatal assessment utilizing the Brazelton Neonatal Behavioral Assessment Scale, Behavioral Observation of the Newborn, Education Tool (BONET) or a similar tool; and,
   - At least two CHAs by 12 months of age, with a referral to a certified Early Intervention Program, if deemed necessary.
7. The percent of mothers' breastfeeding at 6 months postpartum increases above the baseline established in the program's first year.

[2] For some of the children, the 1-year check up will not have occurred yet due to scheduling. They will be measured by the immunizations due at 6 months of age. The specific set of immunizations used to measure this objective will be calculated on whether or not the appointments have been made or completed and other extenuating circumstances that may put children on alternate schedules or qualify for exemptions.

[3]This interval may be modified according to the needs of the client with medical, obstetric, or intercurrent complications.

B GUIDING PRINCIPLES

EI Partnerships standards of care describe program requirements, and are used as criteria by the Massachusetts Department of Public Health for program monitoring. The EI Partnerships standards and all Massachusetts EI Partnerships programs, incorporate in their practice the following guiding principles:

B.1 Respect

Respect that every family has their own unique culture, and EI Partnerships honors the values and ways of each family's neighborhood, community, and extended family.

B.2 Individualization

Supports and services are tailored to each family to meet its own unique needs and circumstances.

Educational materials and services are provided in a manner and format that best meets cultural, linguistic, cognitive, literacy and accessibility needs of the participants.

Programs will make every attempt to hire staff that are representative of the population being served.

Translation/Interpreter services will be provided or bilingual staff will be available.

B.3 Family Centeredness and the Family Care Plan.

EI Partnerships services are guided by the family care plan (FCP), which is developed by the family and MCH team. The FCP is based on family strengths, needs, and resources, as identified through the Comprehensive Health Assessment conducted with the family during the early period of program participation.

The Family Care Plan is a working document produced collaboratively by program staff and family members that contains the agreed upon EI Partnerships services.

Family care plans clearly define the family's goals, service content, frequency, and duration, and the responsibilities of the MCH team and the family in working toward meeting the goals.

At a minimum the Family Care Plan will include a plan for recording:

- The appropriate frequency of primary care visits appropriate questions/talking points that involve the family in their own care.
- Identification of the family's social, emotional, and physical health goals including breastfeeding and nutrition.

B.4 Community

EI Partnerships recognizes that each family exists in the context of a greater community, and fosters these communities as resources for supports and services.

B.5 Team Collaboration

EI Partnerships works as equal partners with each family and with the people and service systems in the family's life.

B.6 Life-long Learning

EI Partnerships supports and services are viewed as a first step in a journey for each pregnant women, mother, infant, family, and provider.

C GOAL 1: EI PARTNERSHIPS WILL IMPROVE ACCESS AND UTILIZATION OF HEALTH SERVICES.

C.1 Standards and Criteria

Standard 1.0: Families served by the program have a completed Comprehensive Health Assessment (CHA).

Criteria:

1.1 The CHA is a health assessment in the broadest sense of the word encompassing the social, emotional and physical well-being of the pregnant woman, mother and infant in the context of their family.

1.2 The CHA includes relevant individual and family health history, screening for current or potential factors that impact optimal health, and physical examination as indicated.

1.3 The CHA includes screening for access to primary health care including prenatal care, medical and mental health services, WIC and other nutritional support, economic support, risk of homelessness and help with meeting basic needs, education and job training, recreational opportunities, and specialized programs as needed, such as substance abuse treatment, domestic violence or legal services.

1.4 Health assessments include the protocol listed under the standards for Breastfeeding, Nutrition, Physical Activity, Mental Health, ATOD use, Domestic Violence, and Health and Safety.

1.5 The Brazelton Neonatal Behavioral Assessment Scale, Behavioral Observation of the Newborn, Education Tool (BONET) or a similar tool is used to observe neonatal behavior and intervene with parents around issues of infant development, attachment and behavior.

1.6 After birth and until 12 months of age, the nurse conducts the CHA and developmental screenings for probable eligibility for EI.

1.7 The nurse conducting the CHA and developmental screenings, either employed directly or indirectly by an Early Intervention program (including salaried, contract/fee for services, or consultant/subcontract), is certified as an Early Intervention Specialist by the Massachusetts Department of Public. (for more information refer to **Early Intervention Operational Standards, January 2003**)

1.8 Developmental screening is conducted at least two times by 12 months of age.

1.9 Developmental screenings are conducted using the Ages and Stages Questionnaire, Battelle or similar *screening* tool.

1.10 Parents are encouraged to be actively involved in the screening, and are respected as the persons with the most knowledge of their child's attributes and abilities.

1.11 Information gained through the screening process is used as the basis for fostering optimal parent-child interactions and activities which promote healthy child development.

1.12 Early Intervention staff will review screening results for potential eligibility for Early Intervention.

Standard 2.0: Families receive health education, brief intervention and counseling appropriate to the families' needs and based on the CHA.

Criteria:

2.1 Health education, brief intervention and risk reduction counseling is family-centered. It is based on the premise that EI Partnerships is to support families explore behavior change if necessary.

2.2 Brief interventions raise awareness, share knowledge and support a person in thinking about making changes to improve their health. It is done for any behavior which affects health, for example, diet, exercise, personal hygiene, smoking, excessive drinking of alcohol, use of other drugs. What is done during a brief intervention depends on the person, the setting, whether the person is ready to change, and whether you are building on previous interactions.

2.3 Health education is provided in coordination with the family's health care provider(s).

2.4 Health education includes importance of prenatal and primary health care.

2.5 Health education includes women's health topics including cardiovascular health, diabetes, breast and cervical cancer, and other topics as indicated.

2.6 Health education includes reproductive and sexual health including family planning, STD, and HIV risk reduction.

2.7 Health education includes preparation for child birth consisting of planning for hospital stay, anatomy and physiology of pregnancy and birth, physical and emotional changes related to pregnancy, danger signs of pregnancy, signs and symptoms of preterm labor, preparation for labor and birth and postpartum changes.

2.8 Health education includes parent-child attachment.

2.9 Health education includes planning for parenthood and the impact on other family members.

2.10 Health education includes normal newborn growth and development.

2.11 Health education includes all routine newborn screenings and appropriate referrals.

2.12 Health education includes the importance of age-appropriate immunizations.

2.13 Health education includes the topics described in the standards for breastfeeding, nutrition, physical activity, mental health, ATOD use, interpersonal violence, and health and safety.

2.14 Health education includes how to recognize and respond to an emergency including:
- How and when to call an emergency provider including fire, police and medical.
- Learning signs and symptoms of complications and how to access emergency care.

2.15 With the participant's approval, fathers, significant others and other household members are encouraged to participate in the education process.

Standard 3.0: EI Partnerships facilitates families' access to reproductive, primary and pediatric care and other community services.

Criteria:

3.1 Families receive information and support on selecting a primary care provider.

3.2 Families are provided with self-advocacy tools to be full partners in their health care.

3.3 Immunization schedules for all children are met and documented.

3.4 The program follows up with the participant's referral source and/or service provider to determine if the participant received needed services.

3.5 Families are supported in accessing health insurance.

3.6 Families are supported to access necessary services as identified through the CHA and FCP.

Standard 4.0: Families are provided with reproductive health education and counseling including family planning and STD/HIV prevention.

Criteria:

4.1 Home visitors are knowledgeable, objective, and nonjudgmental about reproductive health including family planning and STD/HIV prevention.

4.2 Counseling is designed to strengthen decision-making skills, to promote healthful behaviors, and to help participants make informed choices about family planning.

4.3 At a minimum, family planning counseling is discussed by the third trimester and within one month postpartum.

4.4 Education and counseling are given based on participant need and are available on reproductive health including basic female and male reproductive anatomy and the importance of self-examinations.

4.5 Education and counseling are given based on participant need and are available on family planning services including contraceptive use and the value of fertility regulation in maintaining individual and family health.

4.6 Education and counseling includes STDs and HIV risk reduction and disease prevention.

D GOAL 2: IMPROVE NUTRITION, PHYSICAL ACTIVITY, AND BREASTFEEDING INITIATION AND DURATION RATES

D.1 Standards and Criteria

Standard 5.0: Families are provided with breastfeeding education and support services

Criteria:

5.2 With the participant's approval, fathers, partners and other household members are encouraged to participate in breastfeeding education and goals.

5.3 Prenatal breastfeeding education includes anticipatory education on barriers to breastfeeding initiation, physical, social and emotional as well as instructions on initiating and maintaining adequate milk supply.

5.4 Prenatal breastfeeding education and support includes at least two face-to-face contacts.

5.5 Breastfeeding support includes assessment and teaching proper positioning of mother and baby for pain-free breastfeeding.

5.6 Postpartum breastfeeding education and support includes a phone contact with family within 48 hours of discharge and a visit within one week post hospital discharge.

5.7 Postpartum breastfeeding education and support includes an assessment of current infant feeding status, counseling consistent with the mother's breastfeeding goals, and referrals to local breastfeeding support groups or other support sources as needed.

5.8 Breastfeeding education and support continues in all contacts made with the postpartum woman and infant throughout program eligibility, as long as the mother continues to nurse.

5.9 Support and referrals for pumping of breastmilk are provided to breastfeeding mothers needing to be separated from their infants, such as those who return to work or school.

5.10 If the family is enrolled in WIC, with the family's consent, the program coordinates and collaborates with the breastfeeding coordinator, CLC, or IBCLC on staff.

Standard 6.0: Families are provided with nutrition education, physical activity education and support services

Criteria:

6.1 Support and education includes maintenance of a healthy weight, appropriate weight gain in pregnancy.

6.2 Support and education include the importance of regular physical activity upon physician's approval.

6.3 Prenatal nutritional assessment includes monitoring weight gain at each visit.

6.4 Prenatal education includes:

- Personal good nutrition and anticipatory education on barriers to personal good nutrition
- Safe and appropriate physical activity during pregnancy
- Infant feeding

6.5 Food security is assessed with referrals made to WIC, food stamps, and other resources as appropriate.

6.6 Maternal nutrition education and referral includes an assessment of current nutritional status.

6.7 Maternal nutrition education includes education on personal good nutrition and food availability.

6.8 Infant nutrition education and referral includes an assessment of infant's current nutritional status.

6.9 Infant nutrition education includes guidance on:
- Stages of infant feeding
- Development of infant feeding skills
- Nutritional needs for positive growth

6.10 Guidance is provided on safe infant settings that facilitate age-appropriate physical activity and development of movement skills and that do not restrict movement for prolonged periods of time.

6.11 Referrals to local nutrition services and medical care are provided as needed.

6.12 If the family is enrolled in WIC or other nutritional programs, with the family's consent, there is coordination with the nutrition and breastfeeding staff.

E GOAL 3: ENSURE A SAFE AND HEALTHY SOCIAL, EMOTIONAL, AND PHYSICAL ENVIRONMENT.

E.1 Standards and Criteria

Standard 7.0: Families are screened for Alcohol, Tobacco and Other Drugs (ATOD) and provided education about the associated risks.

Criteria:

7.1 Tobacco education includes the dangers of tobacco use and passive smoke.

7.2 Existing tobacco cessation supports are made available to all participants' family members or household members.

7.3 Information and education include the associated risks with ATOD use during the perinatal and early childhood period.

7.4 Home visitors routinely screen for alcohol and other drugs using the 5P's screening tool or other appropriate tool.

7.5 Immediately after any disclosure of substance use or risk of use, home visitors assess dependence, amount, effects, and loss of control.

7.6 Home visitors utilize the brief intervention model including stating medical concern and developing a plan of action with participant.

7.7 Participants' Stage of Change are reviewed at each contact in order to offer the appropriate level of service.

7.8 Referrals are made to the Substance Abuse Helpline and other specialized addictions services and ongoing supports if needed.

7.9 Letters of affiliation with local substance abuse services are obtained that describe EI Partnerships' being a connecting and referral source to substance abuse services and after-care plans.

Standard 8.0: Families are screened for, and given information on, health and safety.

Criteria:

8.1 Education is provided regarding the prevention of major childhood injuries including proper use of car seats, reduction of risk for SIDS, fire and the importance of working fire detectors, falls, poisoning, choking, drowning, shaken baby syndrome, sun safety, safe environments and other issues as needed.

8.2 Information is provided on necessary and safe baby supplies and equipment.

8.3 Vendors subscribe to the US Consumer Product Safety Commission's email list to receive regular recalls involving products that present a risk to children.

8.4 Education includes lead poisoning prevention and environmental asthma management.

8.5 Any safety concerns regarding landlord/tenant issues is referred to housing assistance or legal services.

8.6 If there is any peeling/chipping paint, a referral to the MDPH Healthy Homes program is offered to the family.

8.7 Families are made aware of the Regional Center for Poison Control and Prevention's toll-free number: (800) 682-9211.

8.8 Local resources for car seats and car seat technicians are provided to families.

Standard 9.0: Families receive information on and support for emotional health and healthy parenting

Criteria:

9.1 The CHA includes past or present mental health concerns. Referral indicators include:
- Postpartum depression screening which necessitates follow-up
- Concern about the physical safety of any family member
- Psychosocial or mental health issues which seem to be interfering with the client's ability to benefit fully from program services
- Participant's expression to have counseling for personal issues
- Participant demonstrates need for short-term support to deal with change in life circumstances; ie. grief, transitions, situational stress

9.2 The Edinburgh or Beck postpartum depression screening tool is utilized with all mothers between 4-6 weeks postpartum.

9.3 Referrals are made to the Crisis Intervention Hot Line (1-800-495-0086) and other specialized mental health services if needed.

9.4 Emotional Health and Parenting education is provided on relevant topics such as:
- Recognizing signs of stress and learning appropriate coping mechanisms
- Appropriate expectations
- Understanding infant cues
- Building and maintaining self-esteem
- Supporting healthy communication skills and healthy relationships including decision making, negotiation skills and parenting discipline
- Developmentally appropriate play and learning

9.5 Support is given to the parent-child relationship through proactive prenatal interventions such as preparing for the baby, preparing to mother, developing a nurturing mother-child relationship, and healing past maternal trauma and losses. The Solchaney/NCASTor similar tool is utilized.

9.6 Education is provided on parent-infant attachment and neonatal behavior assessment using tools such as the BONET and teaching videos.

9.7 Referrals are made to parent support and counseling services, such as Mass Family Networks, if appropriate.

9.8 Home visitors participate in care coordination or multi-disciplinary service teams as necessary per client.

9.9 Staff advocate for clients who need assistance in accessing mental health services.

Standard 10.0: Families are informed, screened and assessed for interpersonal violence.

DEFINITIONS:

Interpersonal violence is a broad term used to describe acts of violence among persons within a family or other relationships, including adult and adolescent partners; between a parent or caretaker and a child (including adult children); between caretakers or partners against elders; and between siblings.

Intimate Partner Violence (IPV) is a subset of interpersonal violence. It is defined as a pattern of assaultive and coercive behaviors that may include physical injury, psychological abuse, sexual assault, progressive social isolation, stalking, deprivation, intimidation and threats. These behaviors are perpetrated by someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent, and are aimed at establishing control by one partner over another.[4]

Criteria:

10.1 All women are informed about healthy and unhealthy relationships.

10.2 Home visitors identify community resources for domestic violence and sexual assault prior to implementing screening and assessment protocols.

10.3 Screening is confidential. Prior to screening, clients are informed of any reporting requirements or other limits to provider/client confidentiality.

10.4 All women are screened routinely for current and lifetime exposure to interpersonal violence including direct questions about physical, emotional and sexual abuse.

10.5 Screening should NOT occur unless it can be conducted in private: no friends, relatives (except children under 3 years) or caregivers should be present or in the house.

10.6 Initial health and safety assessments occur immediately after disclosure. The goals of the assessment are to provide the client with information and choices so that she can make informed decisions about her (and her child's) health and safety.

10.7 Follow-up screenings and repeat assessments occur during all subsequent appointments.

10.8 Interventions with victims of violence will be based on the severity of the abuse, the client's decisions about what she wants for assistance at that time and if the abuse is happening currently. Interventions include:

- Initial safety planning.
- Referrals to local advocacy and support systems within the health care setting and community.

[4] Family Violence Prevention Fund (1999). *Preventing Domestic Violence: Clinical Guidelines on Routine Screening*, Family Violence Prevention Fund. San Francisco, CA.

- Referrals to children who witness violence
- Referrals to community based domestic violence programs for expanded safety planing.
- Utilization of the SAFELINK Domestic Violence Hotline, 1-877-785-2020.

10.9 Support and help are offered regardless of whether s/he decides to stay in or leave the abusive relationship.

10.10 Resource brochures should be left if a client is agreeable and feels safe to leave the information.

10.11 Participants are given information about how to obtain a 209A restraining order, and appropriate referrals are made to victim-witness advocates through the local District Attorney Office or local battered women program for assistance with restraining orders, or other legal issues.

10.12 Children who witness violence are assessed to determine whether mental health intervention is necessary, and if so, which services are appropriate.

10.13 Agencies have a written policy for staff in regards to mandated reporting issues involving interpersonal violence they witness or detect in the families they serve.

Standard 11.0: Families are informed, screened and assessed for child abuse and neglect.

Criteria:

11.1 The program develops and maintains written procedures for addressing any suspected incident of child abuse or neglect. It includes, at a minimum:
- Staff report suspected child abuse or neglect to the program director or designee and Department of Social Services pursuant to M.G.L. c 119§51A
- The program director or designee will notify the Department of Public Health, EI Partnerships Services, immediately after filing a 51A report, or learning that a 51A report has been filed, alleging abuse or neglect of a child while in the care of the program or during a program related activity.

11.2 All program staff are trained on agency policy and procedures concerning suspected child abuse and neglect prior to implementing screening protocols.

11.3 All families involved in the program are screened for current and lifetime exposure to child abuse and neglect.

11.4 Screening is confidential. Prior to screening, clients are informed of any reporting requirements or other limits to provider/client confidentiality.

11.5 Initial safety assessment occurs immediately after disclosure. The goal of the assessment is to:
- Create a supportive environment in which the client can discuss the abuse and/or neglect
- Enable the provider to gather necessary information in order to appropriately develop and implement a response.

11.6 Support and help are offered including, but not limited to, referrals to local social support and counseling services as needed.

11.7 The program develops and maintains written procedures for addressing any suspected incident of child abuse by professional staff that includes, but is not limited to, ensuring that an allegedly abusive or neglectful staff member does not work directly with children until the Department of Social Services investigation is completed or for such a time as the Department of Public Health requires.

F GOAL 4: STRENGTHEN PERINATAL AND EARLY CHILDHOOD SYSTEMS THROUGH COMMUNITY COLLABORATION AND FAMILY ENGAGEMENT.

F.1 Standards and Criteria

Standard 12.0: EI Partnerships programs coordinate FIRSTLink for their catchment area.

Criteria:

12.1 Programs provide computer linkage and data transmission including:
- Management of the FIRSTLink database.
- Downloading FIRSTLink names.
- Tracking referrals.
- Retrieving outcome information.
- Returning electronic data to the Department of Public Health.

12.2 Programs provide FIRSTLink follow-up including:
- Contact with families that had an infant or maternal risk factor as indicated on the birth certificate, per current DPH protocols.
- Distribution of referrals of Healthy Families eligible births to the appropriate Healthy Families program or provides follow-up per current DPH protocols.

12.3 Programs promote FIRSTLink through community outreach and education including:
- Distribution of MDPH reports on outcomes and consents to participating hospitals and community organizations.
- Coordination with hospitals and pre-natal care providers to educate parents about program and obtain consents.
- Acting as a contact/liaison for information on local FIRSTLink program.

Standard 13.0: The EI Partnerships program establishes or continues a committee that advises on perinatal and early childhood health.

Criteria:

13.1 The committee assists in on-going program planning, development, and evaluation. This body includes representatives from relevant community stakeholders, such as birth hospitals, health care and social service providers, WIC sites, child care services, Early Head Start programs, schools, community development organizations, local businesses, religious and cultural organizations as well as participating and/or eligible families, and other residents of the community(ies) served.

13.2 Staff must attend appropriate community collaborative meetings to develop strong referral mechanisms, identify community needs, and advocate for and improve available resources.

Standard 14.0: Staff have the required training and competencies.

Criteria:

14.1 All MCH Nurses are trained on childbirth education. Including, but not limited to,:
- Planning for hospital stay
- Anatomy and physiology of pregnancy and birth
- Physical and emotional changes related to pregnancy
- Danger signs of pregnancy including signs and symptoms of preterm labor
- Preparation for labor and birth and postpartum changes

14.2 All MCH Nurses are trained on women's health issues. Including the ability to counsel and assess for issues such as:
- Cardiovascular health
- Diabetes
- Breast and cervical cancer
- Reproductive health and family planning.

14.3 All MCH Nurses are trained on neonatal behavior assessment and teaching points with parents around infant development and behavior.

14.4 Each Program will have at least one staff member who has received advanced training on breastfeeding support. Advanced training is defined by regular attendance at professional development workshops or courses specifically targeting the development of breastfeeding counseling skills. Training resulting in a breastfeeding specialist credential (such as CLC) is preferred. Certification as an International Board Certified Lactation Consultant (IBCLC) is optimal.

14.5 At least one staff member maintains current information on health insurance benefits and eligibility.

14.6 At least one staff member maintains current information on welfare benefits and housing opportunities.

14.7 All Mental Health Clinicians are trained on motivational interviewing, brief intervention techniques, and understanding stages of change related to Alcohol, Tobacco and Other Drugs.

14.8 At least one staff member is trained on families' rights and the lead law and appropriate linkages with Healthy Homes.

14.9 All Staff are trained to:
- Recognize the spectrum of postpartum mood disorder symptoms through questions and observation of the mother, infant, and family,
- Assess parent-infant attachment and parenting skills.
- Utilize 'Promoting Mental Health During Pregnancy' (Solchaney) assessment and teaching tools.

14.10 All staff are trained to:
- Understand the dynamics of domestic violence, the safety and autonomy of abused women, and elements of culturally competent care.

- Know the range of services available through local domestic violence programs and rape crisis centers as well as through hospital- or community health center- based violence prevention programs.
- Know how to ask about whether someone has experienced violence and/or other types of abuse and respond with appropriate information, including initial safety planning, and referrals to local community resources as appropriate.
- Identify signs of and risk factors for child abuse and neglect.
- Understand mandatory reporting laws for children, elders and those with disabilities and methods that can be employed to more safely report when necessary.